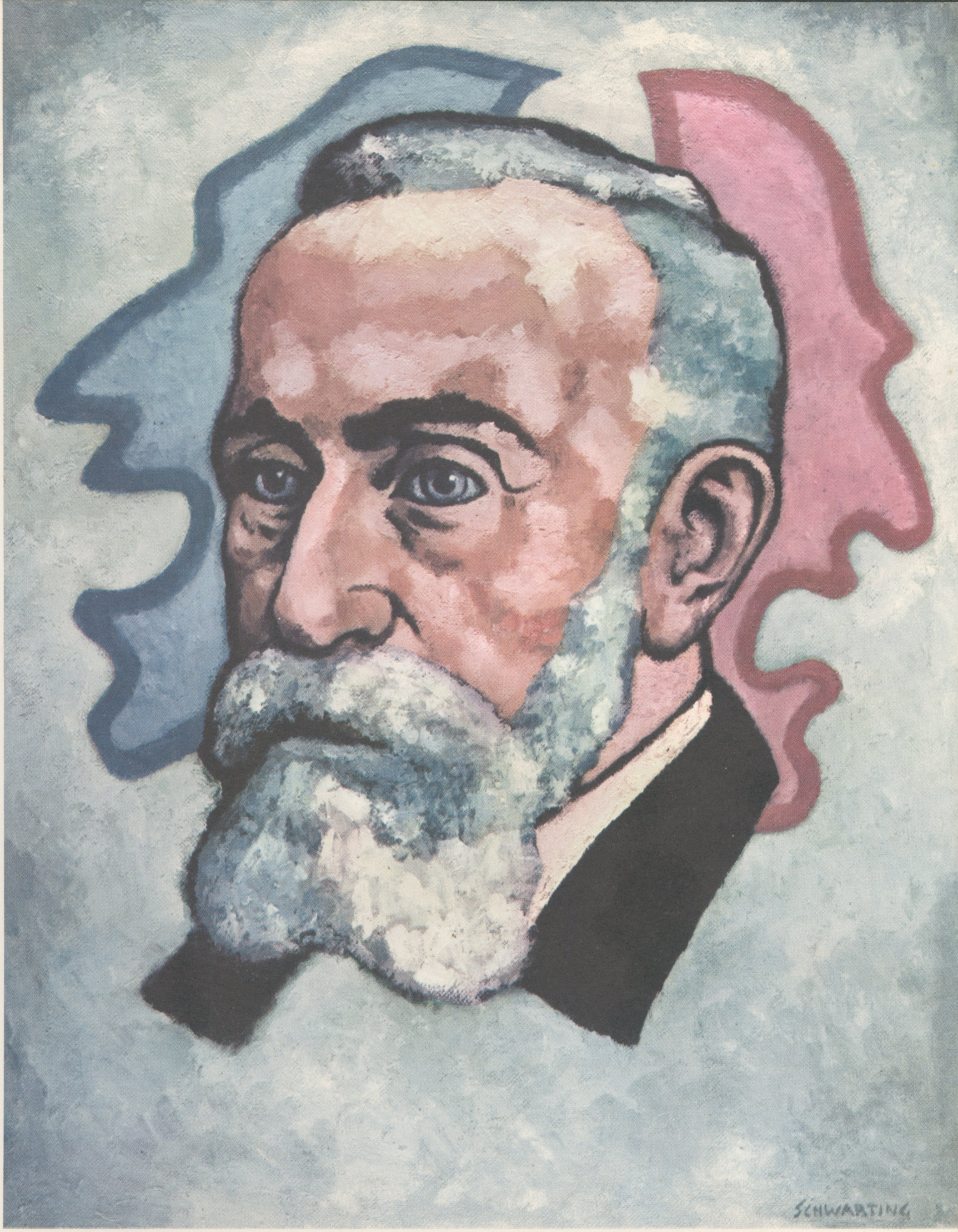
the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE



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for the physician in general practice

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The Cover

● The Swiss psychiatrist, Eugen Bleuler (1857-1939) is depicted in the cover drawing by Joseph F. Schwarting.

● In *Dementia Praecox or the Group of Schizophrenias,* published in 1911, Bleuler revised the entire concept of these disorders. His contribution has been called "the classical work of twentieth century psychiatry." In addition to the designation *schizophrenia,* Bleuler introduced the terms *ambivalence, autism,* and *dereism* which have been employed since he first suggested them. More recently, the value of other concepts that resulted from Bleuler's empathetic understanding of schizophrenics has been generally recognized. A discussion of outcome in schizophrenia begins on page 72.

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CONTENTS

Chronic Emotional Fatigue

● Chronic emotional fatigue was once considered to be a disease entity, for which a variety of etiologic explanations were made. In the mid-19th century, Beard introduced the term *neurasthenia* to designate a literal "waste of nerve tissue in excess of repair." The term *nervous exhaustion* was employed synonymously. The concept of emotional fatigue as a specific disease of the nervous system was well received at that time, and, for more than 60 years, the idea persisted that the disorder was caused by a kind of nerve-weakness. Now, of course, both the term neurasthenia and its connotation are obsolescent.

Later theories of cause have included faulty carbohydrate metabolism, endocrine dysfunction, imbalanced hypothalamic activity, and others. Although none of these has been proved, it has been established that a prolonged state of emotional fatigue frequently produces measurable physiologic consequences. Further investigation of psychophysiologic reactions to stress and their relationship to fatigue are now in process.

Fatigue of any kind is a symptom, the origin of which may be organic or emotional. There are some distinctive features of different types of fatigue which are helpful in determination of cause. For example, ordinary tiredness which occurs after strenuous physical exertion or intense mental concentration is a transitory reaction which, normally, is resolved by rest. Pathologic fatigue, however, is disproportionate to the degree and kind of activity, and is not dissipated by rest. When fatigue is the predominant symptom of organic disease, debilitation has usually resulted from an advanced disease process and the disorder will be relatively easy to diagnose. There are exceptions to this, of course, and evaluation of a patient with chronic fatigue should include complete physical, laboratory, and roentgen examination.

The emotional origin of fatigue is usually suspected after possible organic causes are excluded by physical examination of the patient. Obviously, unrelated physical illness and psychogenic fatigue can coexist, and, therefore, the nature of the patient's fatigue is diagnostically important. The specific features of psychogenic fatigue are as characteristic as those of fatigue which results from organic cause. For example, emotional fatigue is more intense in the morning, with a tendency to abate during the latter part of the day. The symptom complex of chronic emotional fatigue also includes difficulty in concentration and in making decisions, irritability, lack of initiative, reduced social interests, emotional hypersensitivity, and impairment of sexual function. Narcissism and hypochondriacal tendencies may be evident. Furthermore, such signs as undue concern or excessive apathy about symptoms, as well as unusual emotional response to any question or an evasive reply, are all indicative of underlying emotional disorder. Disorders in which fatigue may be a prominent symptom include anxiety reaction which has become chronic, depressive reaction, and early schizophrenia.

Chronic emotional fatigue is a common symptom, the prevalence of which has been attributed, in general, to culturally fostered conflicts between aggressive ambitions and dependency wishes. Individually, emotional fatigue is a potential result of any kind of psychologic conflict. Because of painful past situations, the individual fears, subconsciously, that his future conduct may upset the ideal image of himself, as defined by his relationship to others. The response, then, is to desist from activity, and this is expressed symbolically by the attitude of fatigue.

The symptom of emotional fatigue may represent a reaction to adverse extrinsic conditions, or it may be part of a complex defensive management of intrapsychic stress. Laughlin observed that ". . . considerable expenditure of emotional effort and energy is required to maintain repression." Rejected impulses and wishes continue to exert pressure even after repression. Therefore, the mechanisms of inhibition, control, or denial may, of themselves, result in emotional fatigue. Furthermore, if the defensive structures seem threatened, the symptom of fatigue may develop as a kind of reinforcement. Unconsciously, regression to less activity seems to decrease the likelihood of unacceptable behavior, and reduces the sense of personal responsibility for behavior. Inactivity not only helps to prevent expression of unwelcome impulses; it also protects neurotic defenses from exposure. Consciously, fatigue is a socially approved manifestation. It may even enhance self-esteem because of the inherent implication that such disorder is a consequence of hard work.

Psychodynamically, emotional fatigue is closely related to depression. In both states there is withdrawal toward physiologic dormancy. Fatigue may be the first manifestation of depression or it may occur concomitantly. Depressive fatigue results from the psychic effort to repress prohibited impulses, hostile and aggressive. Failure of repression leads to an inversion of the impulses, and depression results. Despite the similarities between fatigue and depression, the clinical manifestations are distinct. For example, self-punitive


SCHWARTING

or masochistic elements are not usually as pronounced in patients with chronic emotional fatigue.

There are several factors which may predispose an individual toward selection of fatigue as a symptom. In infancy, the frustration of vital dependency needs and mismanagement of infantile hostile-aggressive responses can result in a subsequent fatigue syndrome, as well as in other emotional disorders. More specifically, in childhood, parental conditioning may make "tiredness" an excuse for undesirable behavior. This concept may later be recalled as a means of management. Other factors include lack of interest, motivation, or incentive. Even where there is interest, such reactions as disappointment, disillusionment, or discouragement may result in fatigue. It is common for a fatigue state to occur after an individual has had to abandon a cherished goal or occupation and resign himself to pursue a monotonous routine. Boredom may be a significant aspect of fatigue. Fenichel has described boredom as the result of a wish for an outlet for some repressed impulse. Substitute activity does not satisfy, either because it is too far removed from the unconscious goals or because it is close enough to stimulate, and, thus, cause discomfort as a threat to repression. Therefore, interests and activities are inhibited. It has been noted also that, in everyday usage, the words "tired" and "bored" are frequently used interchangeably.

The following case history illustrates some of the significant features of chronic emotional fatigue. A 34-year-old engineer had been referred for psychiatric care because of chronic fatigue. Although he had experienced some difficulty in concentration, he had had a succession of excellent positions in which his work was described as brilliant. In each position, however, he worked only a short time and then resigned to rest, regain strength, and, in his words, "recoup energy." During the intervals between work, he would simply lie around the house—an occupation in which he seemed most content. This behavior had continued for years.

The patient was unmarried and lived with his mother, who was sympathetic about his fatigue and overly protective toward him. She encouraged his indulgence of dependency wishes, and, in so doing, unconsciously implied that she would satisfy all his needs. Since, realistically, this was impossible, the patient experienced extreme frustration. Subconsciously, he felt intense hostility toward the denying object. The threat of uncovering infantile dependency needs and aggressive impulses was intolerable, and, because he doubted the effectiveness of his control, the patient resorted to fatigue as an added defense measure. By this means, he became "too tired" to act upon aggressive impulses. The patient was treated successfully by psychoanalysis, although the process was difficult and prolonged. He later married, and has maintained a stable professional relationship.

A number of different treatment methods have been employed for patients with chronic emotional fatigue. In general, physical methods provide only temporary relief, if that. Furthermore, such regimens as enforced rest not only gratify neurotic dependency needs but also actually foster them. For example, a patient who was advised to reduce his working time to four hours a day became increasingly exhausted, and, of his own volition, spent the remainder of each day reclining at half-hour intervals. The reported success of S. Weir Mitchell's routine of enforced rest and dietary therapy has been attributed to this therapist's dynamic personality and its effect upon patients. This belief was substantiated by the high rate of individual relapse when the rest routine was discontinued.

The administration of stimulants has been advocated from time to time. The most popular of these were caffeine and the amphetamines. Such drugs may temporarily decrease awareness of fatigue and promote wakefulness. However, since there is pronounced underlying tension in fatigue which results from emotional conflict, stimulants may simply increase distress, and, thereby, promote the need for additional defense. In selected cases, adjunctive use of a drug may be beneficial as long as the patient understands that it is not the principal therapeutic agent.

The greatest danger in overemphasis of physical aspects of chronic emotional fatigue is that the patient then will be directed away from recognition of causative emotional factors. Later, it may be extremely difficult to develop in him any constructive interest in self observation. Chronic emotional fatigue is a faulty response to psychic stress. Consequently, the treatment of choice is psychotherapy. The origin of conflict must be determined first. The patient is then made aware of the adverse effects of his defense mechanisms, and, gradually, is helped to achieve a higher level of maturity.

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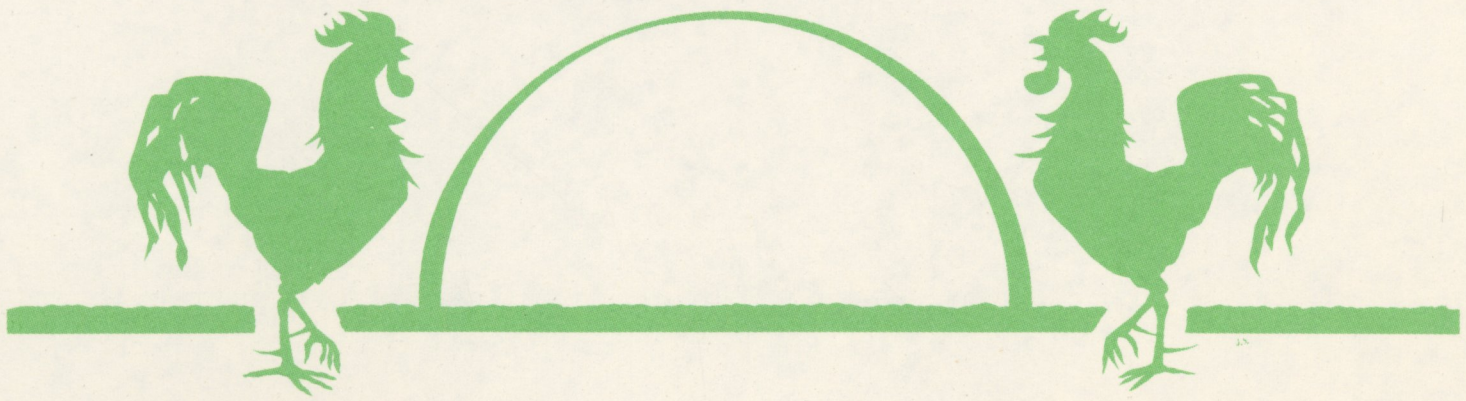

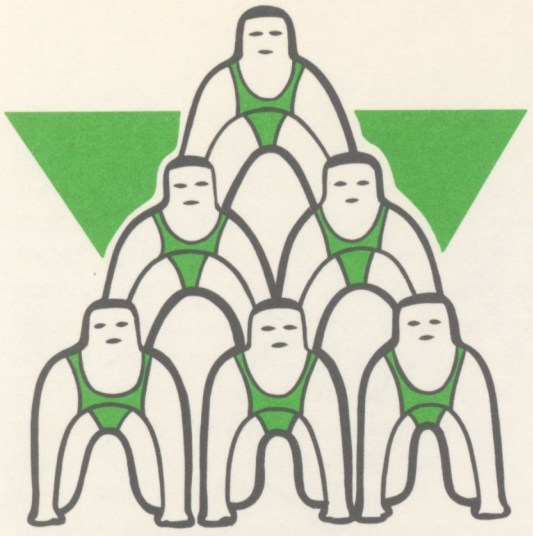

Group Psychotherapy

● IN GROUP PSYCHOTHERAPY, the members of the therapeutic group are usually selected within such pre-existing groups as hospitalized patients, clinic patients, or prison inmates. Less commonly, groups have been made up of patients treated in private practice. Candidates for participation should have a willingness to join a group and to work toward recovery. Furthermore, the individual should have either sufficient ego-strength to sustain him during group interaction or previous psychiatric care with some resultant insight.

Objectives

The objectives are, of course, the same as those of individual therapy. The reason for a group approach is that, in some cases, patients are likely to respond better with the stimulation of group interaction.

Some of the advantages of group psychotherapy are the diminution of feelings of isolation, support from other members, encouragement of self-expression, opportunity for reality-testing of individual concepts, and development of interest with subsequent clarification and insight. Incidentally, it has been noted that group participants gain insight into the mechanisms of defense employed by other members first, and from this understanding may develop insight into their own maladaptations. Finally, the transference formed in group psychotherapy is more superficial than the regressive type evolved in individual therapy, and is, therefore, easier to terminate.

Methods

There are several techniques employed in group management, and innumerable variations of these more or less basic approaches. For example, in the lecture method, which was introduced by Pratt in 1905 to encourage and instruct patients with tuberculosis, one therapist talks to several hundred patients. In contrast, there is a method in which as many as a dozen therapists meet with one patient. Another technique is that of psychodrama in which patients re-enact personal problematic situations. This method was developed after Moreno wrote short plays for children which were intended to help them express some of the usual problems of childhood. The children, however, ignored the lines and roles they were supposed to play and introduced their own, far more revealing ones. Finally, there are the directive and non-directive approaches. An example of the directive approach is that employed by Low who dictates the topics to be discussed by the group and instructs the patients in special terminology which they must use to express their thoughts. A contrasting method is the one employed by McCann who leaves the room as soon as the group is ready for discussion and does not return until the session is over. Obviously, these last illustrations represent extremes of viewpoint. Most group therapists are essentially non-directive but remain a part of the group, observe the interaction, and interpret or interrupt when necessary. Some investigators divide the techniques of group psychotherapy into two classifications, static and dynamic. The lecture method is considered the static type and psychodrama, dynamic. As Masserman pointed out, however, in operation either method can be the converse of the other. For example, psychodrama can be simply a miming of irrevelant superficialities, and a lecture can evoke emotional group experience which results in actual constructive reorientations.

Results

One of the most commonly used methods of group psychotherapy is that in which a small group of four to eight members meets with a therapist for hourly sessions once or twice weekly. The results of this type of therapy can be illustrated by the reports of several therapists.

Hadden recently reported therapeutic results in a group of overt homosexuals. In individual interviews before treatment the members denied emphatically any wish to change their sexual orientation; they had agreed to treatment only because of family insistence. Discussion in the first group session began with general statements that homosexuality is the preferable orientation. The participants then discussed a newspaper report of the recent murder of a homosexual whom they all knew. This topic evoked some anxiety, and the session ended with an unanswered question about why homosexuals destroy themselves and each other. In subsequent sessions, the initial rationalization was subjected to critical examination by the members. With the admission of feelings of isolation, loneliness, anxiety, and depression, there was a tendency to admit fallacy in this reasoning. As a result, anxiety about deviant behavior was activated, with a subsequent wish to change. Identification with a group motivated toward socially acceptable goals helped to provide ego-strength and alleviate the sense of isolation. Furthermore, as each individual attempted to alter his concepts, the other members offered support and encouragement. Some members left the group, of course, and those who remained did not change rapidly. Indeed, changes in adaptations other than sexual ones were usually noted first. For example, jobs were obtained by group members who had been supported by their families. Mode of dress and mannerisms became less effeminate. Later, two members of the group reported heterosexual interest.

Two recent reports illustrate some of the particular problems in group therapy of adolescent delinquents.

Straight and Werkman have conducted group sessions with eight extremely aggressive, hospitalized boys, aged 14 to 20 years. The patients had all experienced rejection at home and subsequent custodial care because of impulsive and hostile "acting-out." The diagnoses included schizophrenic reaction of the catatonic type, emotionally unstable personality, sociopathic personality, and mental deficiency. The special problem with this group was the control of fighting and generally disruptive behavior. Two therapists and an attendant were present at each session. The immediate objective was to establish disciplined behavior. This was done by having the group meet in the same place at exactly the same time with the same therapists; by provision of indestructible furniture in an otherwise bare room; and by active intervention in fights. Efforts were made to promote interest in socially acceptable goals and encourage consideration for other persons. The participants tested and retested the limits for acceptable behavior before any form of constructive verbal expression occurred. The central theme of discussion, however, was the concept of self-promotion and indifference to others. Gradually, the group rejected one particularly disruptive member, and joined in the protection of a quiet one. Finally, the group became cohesive and settled down to work with specific problems of adaptation. The improvement in each member was noted especially in the recreational activities elsewhere in the hospital.

Kotkov described the other group of delinquent adolescents. The subjects were nine girls, aged 14 to 17, who had volunteered for treatment. None of the girls had progressed beyond the tenth grade in school, and all of them had been institutionalized because of truancy, sex delinquency, vagrancy, and incorrigibility. The first two group meetings were chaotic. In the next sessions, there was a period of testing the therapist by defiance, use of lewd vernacular, and generally provocative behavior. Kotkov noted that the patients seemed to demand alienation by forcing rejection. By the seventh session, however, the group had become more subdued, and the members began to discuss seriously their experiences and feelings. Almost all of the members expressed, finally, a pronounced fear of the sexual relationships. In addition to this fear, there were feelings of guilt about previous behavior and anticipation of inevitable punishment. At the end of four months of weekly meetings, the results were evaluated by the therapist and the superintendent of the girls' school. The therapist reported evidence of loss of fear, less hostility and aggressiveness, and greater warmth in interpersonal relationships. The superintendent stated that the girls seemed less tense, accepted correction without resentment, and exerted a stabilizing influence upon some of the other girls in the institution.

The last example of the results of group psychotherapy is that of a group of discharged patients who had been hospitalized because of psychotic disturbances. In most mental hospitals, group psychotherapy is offered to patients before they are discharged in order to provide opportunity for reality-testing of newly acquired social adjustment. Blau and Zilbach have suggested, however, that continued group psychotherapy for a period after discharge would help to ameliorate the actual problems which develop in readjustment to family and community. Some of these problems cannot be anticipated until the patients have returned to their own specific life situations.

Blau and Zilbach conducted weekly sessions of one hour for a year after discharge with a group of eight women with diagnoses of manic-depressive reaction, schizophrenic reaction, involutional psychotic reaction, and alcoholism with psychotic reaction. The patients' ages were 24 to 55, and all had been hospitalized for mental illness more than once. As the sessions started, the therapist simply stated that the purpose was to discuss any problems the members might have. During the first sessions, the conversation was superficial and included such topics as jobs, housework, and church activities. Such items as mental illness, fear of rehospitalization, and personal problems were avoided. A few participants mentioned difficulty in meeting people, but this was quickly attributed to memory impairment after electric shock treatment. After a month of meetings, the members seemed to be less formal toward one another, but still did not discuss personal difficulties. Shortly thereafter, a new member joined the group. She was immediately questioned about her illness and problems, in contrast to the previous policy of the group to refrain from questioning each other. Since nothing adverse happened to the new member who had spoken freely, the others soon began to discuss their own problems. Apparently, there had been a fear that any expression of hostility would result in punishment, and that admission of concern about mental illness might result in rehospitalization. The meetings continued for a year, during which time the participants were able to discuss their difficulties and learned to recognize and accept constructive advice. None of these patients has been readmitted. In order to evaluate the effectiveness of the sessions, comparison was made between performance before and after treatment. Significant improvements in social, marital, and job adjustments were demonstrated.

Despite the different approaches in group psychotherapy, there has been a definite consistency shown in beneficial results. This would seem to indicate that the group itself, regardless of the particular procedure, has inherent therapeutic potentiality.

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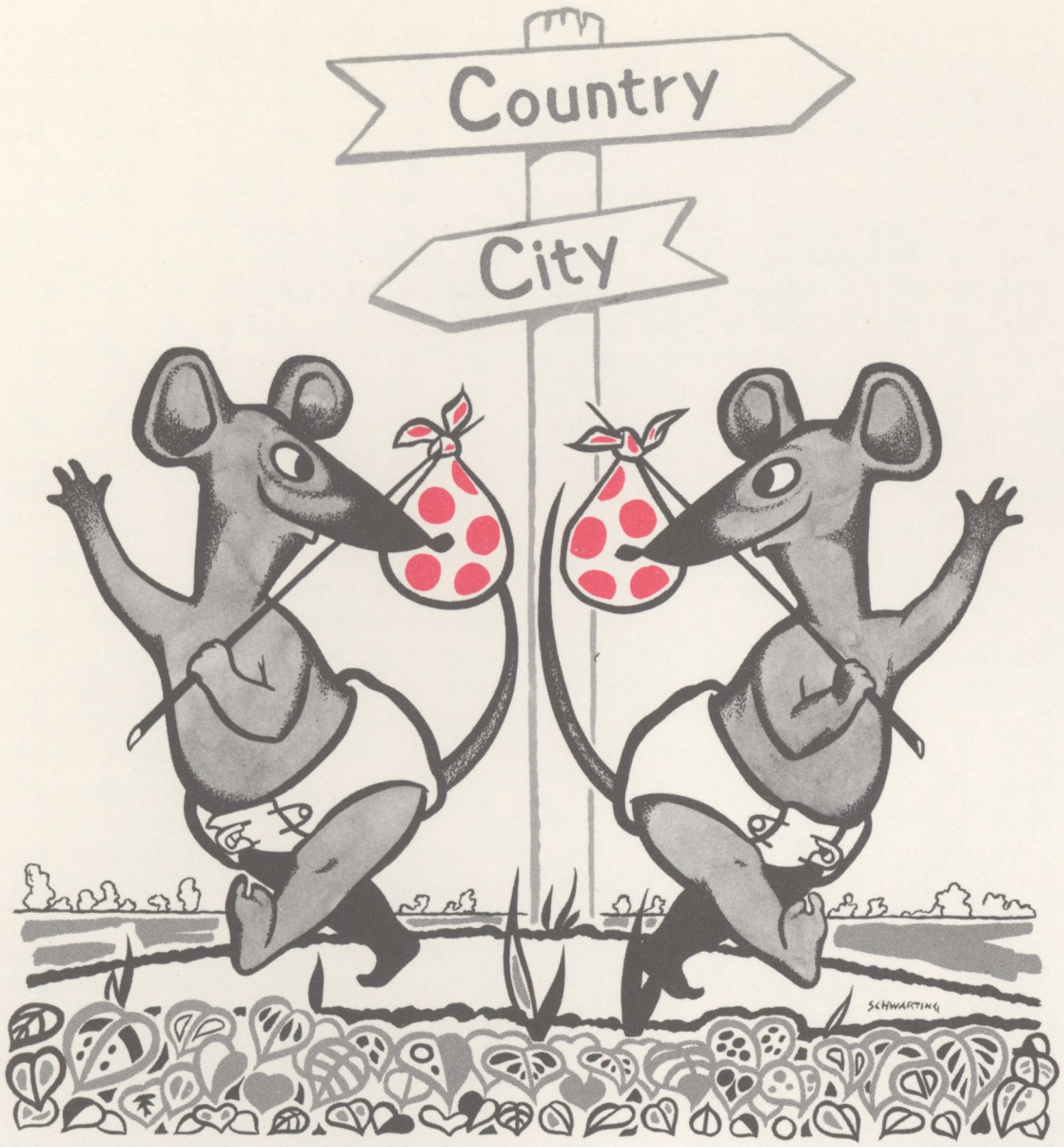

Twins

● Approximately 25 per cent of twins born in this country are monozygotic. The incidence of stillbirth in monozygotics is twice that of dizygotics, and is six to seven times greater than that in single births. A suggested reason for this frequency is that, since monozygotic twins share one placenta and one amniotic sac, there is a likelihood of damaging effects from one fetus' interference with the other. The process of birth is more hazardous for twins than for singletons. About 50 per cent of twins are born prematurely, malpresentation is common, and brain injury occurs more often than it does in ordinary births. The death rate is high among twin infants and the survivors' growth is retarded during the first year. After this period, the life expectancy and physical growth are the same as those of other children.

Opinions differ with respect to the intelligence quotients of twins. Some investigators have reported no difference in average from other children. Others have stated that the average intelligence quotient of twins is slightly lower than that of nontwins with comparable background. Intelligence test scores of one pair of monozygotic twins differ from each other only to the same degree that one child's score may vary by several points at different times.

Most twins are retarded in language development. For example, in a study of a group of five-year-old twins the individual vocabulary average was 158 words, a number considered normal for a two and one-half to three-year-old singleton. Probably twins feel less need to communicate with others because of the constant companionship inherent in their own relationship. The necessity for verbal intercommunication is lessened by shared experiences, and often a system of gestures and vocal cues supplants, in part, the everyday conversation between them. Although this environmental consequence is understandable, its implications for later social adaptation and learning are unfortunate. Language underdevelopment inhibits exchange with other children and adults, and inadequate concept of linguistic symbols results in greater difficulty in abstract intellectual function. In mechanical ability, intelligence, and educational achievement, monozygotic twins resemble each other more closely than do dizygotic twins.

Behavioral manifestations

Usually, monozygotic twins behave more amicably toward each other, have a kind of reciprocal dependency, and maintain similarity as they grow older. Dizygotic twins are likely to be competitive, and they become less alike as they grow older.

Twins who are reared together, particularly monozygotics, seem to adopt special patterns of behavior which are complementary. For example, one twin may be the spokesman, lead in activities, and make decisions. The distinct behavior pattern of each twin may be initiated because of a slight difference in size or strength, or even by some chance happening. Usually, the arrangement results in economy of effort and a harmonious relationship. When it is continued and augmented for years, the consequence is demonstrated by personality differences. The division of roles is believed to account for different interests, attitudes, and emotional reactions in adult twins. The effect of dissimilar environments has been demonstrated in studies of monozygotic twins who were reared apart. For example, twin girls were separated at the age of five months, and one was reared on a farm, the other in a small town. The twins were examined at the age of 29, and showed considerable difference in intellectual, emotional, and physical characteristics. The twin

who had been reared on a farm was robust, stolid, and stable in emotional response. Her intelligence quotient was 89. The sister was underweight, worrisome, and labile in emotional response. Her intelligence quotient was 106. According to Kanner, even though identical twins are genetically as much alike as humans can be, experience does affect development of personality and does, of course, make for individual differences.

Theoretically, monozygotic twins who are reared apart but in similar environments would be expected to be more alike in personality than those who are reared together. Although it is difficult to assess similarity of environments, the findings in studies where this was attempted have confirmed the theory. Because of identical heredity, similar physical attributes, and elimination of the personality determinants in twin interaction, separated monozygotic twins seem to respond alike.

Emotional problems

Although there are no psychogenic disorders peculiar to twins, some features of the relationship are conducive to particular emotional problems. Perhaps the most pronounced of these features is rivalry. Fenichel observed that, "Twins readily develop ambivalence and jealousy, an intermingling of a feeling of dependence, in the sense of needing a supplement to become a whole, and a hostile reactive stressing of independence."

Pearson reported a case history which illustrates the reaction of hostile independence. The patient, a ten-year-old girl, was referred because of her defiant, rude behavior, antagonism toward her twin sister, and extreme brutality toward younger children. The patient's parents were Jewish, but she became Catholic, and perfervidly anti-Semitic. She was vehement in approval of a political party opposite to that supported by the rest of the family, and professed admiration for Hitler and the tenets of Nazism. The patient had been expelled from four schools and a summer camp because of disobedience and use of obscene language. Her attacks upon younger children were violent. A review of the twins' history showed that during infancy they had been alternately breast-fed and bottle-fed, and the mother left them for a week when they were weaned. At the age of three, the twins had pertussis. The patient suffered more severe coughing paroxysms and frequent vomiting. This circumstance resulted in greater attention. The patient developed an ability to vomit at will, and continued to do so in order to receive more attention than her twin sister. The attention, however, was in the form of punishment. Later, scatologic speech was substituted for vomiting, with similar results. During analysis, it became apparent that the patient felt intense anxiety in the twin relationship, resented the need to share with her

twin, and dreaded the thought that her mother might have another child. These attitudes were extended to resentment of all other children, as younger children were considered as rivals. In addition, aggression toward small children resulted from identification with the adults who had chastised her. In analysis, the patient said that she was the less preferred child, and expressed a wish to be born again without a twin.

Abraham cited a case history of a 31-year-old twin who experienced confusion of identity. In dreams and fantasies, she seemed uncertain whether she was a complete person or a part of her twin brother. Strong resentment of her twin was shown in some instances. For example, the patient fantasied that her brother had monopolized all the space in the uterus, had crushed her, and had pushed her aside in order to be born first. Ambivalence was demonstrated in another fantasy in which the patient wished to be joined to her brother as Siamese twins are.

These case histories are, of course, illustrative of psychogenic disturbance. The first patient's diagnosis was character disorder (antisocial behavior reaction). The second patient's was anxiety hysteria. Actually, the incidence of neurosis is no greater in twins than in the general population. When psychosis occurs in one of monozygotic twins, however, a tendency toward similar involvement of the other twin has been observed. For example, in a study of 174 monozygotic twins with schizophrenia, 85.8 per cent of the co-twins were also schizophrenic patients.

Lesser problems of competition and jealousy often increase in adolescence. Conversely, a more pronounced dependency may develop. Twins who have become accustomed to identity as a unit, frequently have great difficulty in establishing separate adjustment in such situations as, for example, marriage.

Unavoidably, twins receive a certain amount of attention simply because they are twins. If this can be balanced by assurance of love as individuals, each twin will be more likely to achieve mature adjustment. Insofar as emotional problems can be avoided, the best method is to encourage differences. Emphasis should be upon individual achievement which is unrelated to twin status.

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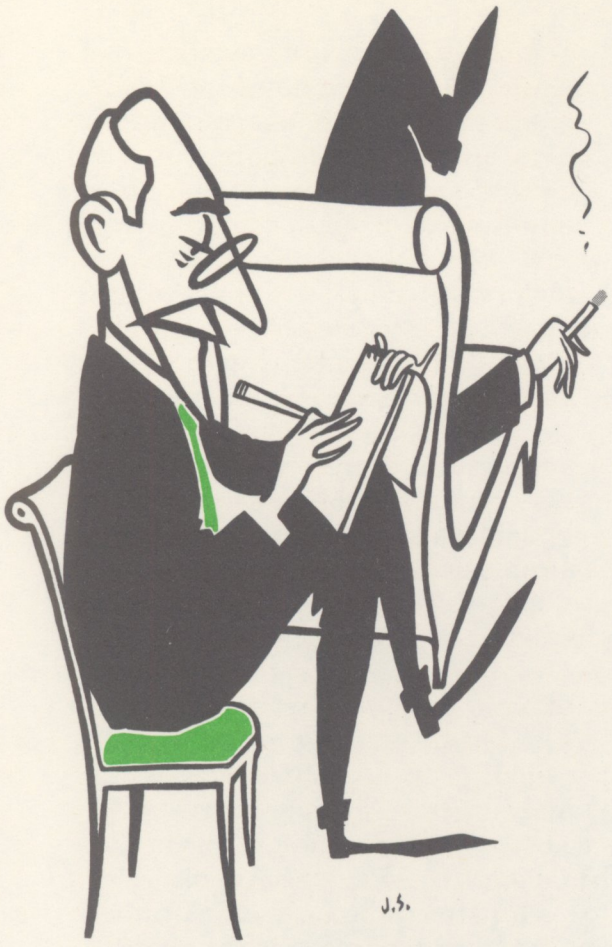


Book Reviews

● Social Class and Mental Illness. *By A. B. Hollingshead, Ph.D., and F. C. Redlich, M.D. Pp. 442. Price $7.50. New York, John Wiley & Sons, Inc., 1958.*

This initial presentation of a research project in New Haven is subtitled *A Community Study*. Actually, both this and the part subsequently to be published, may be suitably so called. The purpose is that of inquiry into the relationship if any of mental illness and social stratum, as well as the problem of social status as related to the sort of therapy a mentally disordered patient receives. The community, the patient, the psychiatrist, and the institution are all to be considered if a class effect is to be ascertained.

There are twelve chapters in this book, the first part of the reported results of ten years' study. There are name and subject indices afforded, and the reading references are cited by chapter. Some of the findings are presented in tabular form in number four of the appendices.

● The Changing Patient-Doctor Relationship. *By Martin G. Vorhaus, M.D., F.A.C.P. Pp. 311. Price $3.95. New York, Horizon Press, 1957.*

In his introduction the author remarks the increasing importance of a successful relationship between physician and patient for any sort of therapy to be used effectively. Rapport is essential to the practice of medicine, and the universal difficulty of communication is reflected in the imperfect understanding between professional and lay groups. Dr. Vorhaus's thesis and his recommendations are narrated simply and directly, and he utilizes five hypothetical case histories by way of emphasis. The book is illustrated with drawings by A. Birnbaum.

● A Text-book of Psychiatry for Students and Practitioners, *8th edition. By Sir David Henderson, M.D., F.R.C.P., and the late R. D. Gillespie, with the assistance of I. R. C. Batchelor, F.R.C.P., D.P.M. Pp. 746. Price $10. London, Oxford University Press, 1956.*

It has been six years since the last edition of this text, the first version of which appeared in 1927. In the preface the author remarks the necessary alterations in the passages on the subjects of etiology, physical therapy, epilepsy, paranoia, and the illnesses of psychogenic origin. The volume opens with a short historical review and closes with a chapter on forensic psychiatry. The other 18 chapters contain a great deal of clinical material by way of illustration and demonstration. The bibliography is brief, but many references are given in the body of the text, and the volume is fully indexed.

● Current Practices in Mental Hospital Administration. *By the American Psychiatric Association Mental Hospital Service. Pp. 75. Price $2. Washington, the Association, 1957.*

This collection consists of articles that appeared in the periodical Mental Hospitals during the last year, bound together for reference usage. The literature on mental hospital administration is admittedly insufficient, so that materials of this sort are needed and welcome. There are 29 contributors, and each paper treats of a different aspect of administrative procedure. The preface is by Winfred Overholser, M.D., Chief Consultant of the A.P.A. Mental Hospital Service and Chairman of the Committee on Certification of Mental Hospital Administrators.

● Roots of Modern Psychiatry. *By M. D. Altschule, M.D. Pp. 184. Price $5.75. New York, Grune & Stratton, Inc., 1957.*

The nine essays in this collection are about the history of psychiatry, and afford varied and colorful reading. The author states in the preface that he considers knowledge of historical development more important in this science than in any other phase of medicine. That importance is implicit in the title, of course, and the history of theories of medical psychology repeatedly demonstrates the recurrence of ideas, the opposition to be expected, and the influences of conflicting metaphysical systems. The subjects of the individual papers are sufficiently different and controversial to maintain lively reader interest, and the notes and references are almost equally rewarding. Among the topics discussed are anxiety in 18th century medicine, the evils of civilization as construed in the mid-nineteenth century, the concept of unconscious cerebration, and the function of the pineal gland.

● The Annual Survey of Psychoanalysis, *Volume IV. Edited by J. Frosch, M.D., and N. Ross, M.D. Pp. 770. Price $12. New York, International Universities Press, Inc., 1957.*

This issue of the survey presents abstracts of the important papers of 1953 on the subject of psychoanalysis and related disciplines. Ego psychology, problems of training, and problems of development received increased interest in the publications of that year, so that the survey selections necessarily represent that interest. Seventeen books and more than 250 articles have been surveyed.

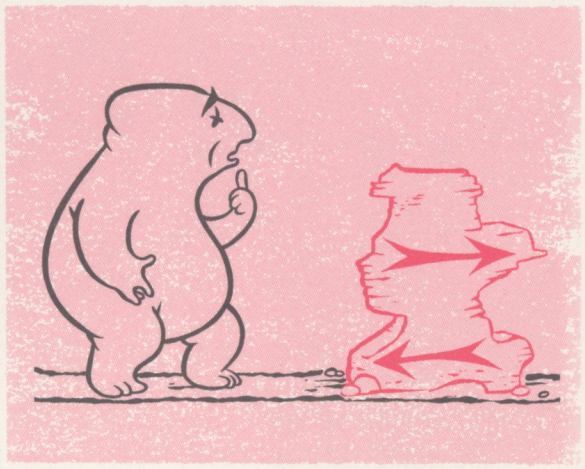
BOOKS RECEIVED

The Horizontal Hour. *By Robert W. Marks. Pp. 346. Price $4.50. New York, David McKay Company, Inc., 1957.*

Character Disorders

● Character disorders result from patterns of adaptation in which ego function is restricted or distorted. These maladaptations differ from the neuroses in several ways. First, the individual does not experience anxiety about his deviant behavior, although it may cause distress to other persons. Second, the individual with character disorder "acts out" impulses instead of employing the fantasy of neurotic symptom formation. Third, character disorder affects the total personality, inhibits emotional growth, and limits flexibility of adaptation. In contrast, a neurotic symptom usually affects only one aspect of adjustment. Laughlin described the incidence, 18 to 20 per cent, of character disorders in clinical practice as higher than that of any other form of non-psychotic mental disturbance.

According to Freud, ". . . the permanent character-traits are either unchanged perpetuations of the original impulses, sublimations of them, or reaction-formations against them." Character traits are formed during several early developmental stages, customarily referred to as oral, anal, and genital phases. These terms are applied to character development because it is believed that particular traits are formed when each type of psychosexual development is predominant. For example, such components as self-confidence, optimism, dependency, curiosity, enviousness, generosity, and their opposites are associated with the oral phase. Frugality, orderliness, punctuality, meticulosity, and obstinacy are associated with the anal phase. Ideally, in the genital phase the greatest advances are made in character formation. Ambivalence is overcome, the Oedipal situation is resolved, and guilt feelings from infantile sources are subjugated. With an outlet for release of excitement, reaction formations are no longer necessary, and ability to sublimate can be fully developed. In individuals who do not complete this transition successfully, however, the pregenital forms of eroticism retain their original attributes. The phases of emotional development overlap, and progress varies individually. In addition, the environmental influences and the specific individual reactions are also instrumental in character formation. The individual with character disorder is recognized by the overdevelopment of some characteristic or group of characteristics. Obviously, the diversity of possible manifestations is unlimited. There are, however, a few types of character disorder which have been observed frequently enough to be described as distinct entities.



Ego, the rational part of man's mental structure, organizes, directs, or suppresses stimuli.

Character disorders are divided into three main groups, partly on a descriptive basis and partly in accordance with the psychodynamics of their formation. The groups are personality pattern disturbances, personality trait disturbances, and sociopathic personality disturbances.

The first main group, that of pattern disturbance, is distinguished by formation of basically unalterable character structure. Prolonged therapy may result in improvement, but fundamental change can rarely be achieved. The following types are included in this category.

Inadequate personality — deficient response to ordinary stimuli, pronounced lack of adaptability and ineptness, with little physical or emotional stamina.

Schizoid personality—avoidance of close personal relationships, inadequate expression of aggressive feelings, and autistic thinking.

Cyclothymic personality — alternate moods of elation and depression which result from internal factors instead of external stimuli.

Paranoid personality — extreme sensitivity in relations with others, and a kind of projection mechanism in which suspiciousness, envy, and obstinacy are predominant.

Persons in any of these categories may achieve social adjustment under favorable circumstances. However, the lack of flexibility inherent in the character structure is such that, under conditions of stress, the individual is likely to become psychotic.

The second main group is that of personality trait disturbance. Individuals in this category have developed fixed exaggeration of particular behavior patterns, or have regressed to such patterns because of continued environmental stress or inner emotional stress. The manifestations may appear to be similar to neurotic symptoms, but they are different because such features as anxiety or depression are not significant, and the problems are intrinsic, in contrast to superimposed neurotic symptoms.

Emotionally unstable personality —reacts to minor stress by hyperexcitability and inefficiency, and, because of pronounced ambivalence, emotional attitudes fluctuate in interpersonal relationships.

Passive-aggressive personality — may be demonstrated in several ways: the passive-dependent individual appears to be helpless, indecisive, and maintains child-like dependency; the passive-aggressive type evidences hostility by sulkiness, obstinacy, procrastination, and inadequate performance; the aggressive type is more overtly destructive, reacts to frustration by temper tantrums, and, despite feelings of strong resentment, is overly dependent. Each type of passive-aggressiveness may be evidenced at different times by the same individual.

Compulsive personality—overconscientiousness, emotional inhibition, and unusually strong need to conform; may show exceptional capacity for work, but performance is rigid and enjoyment of

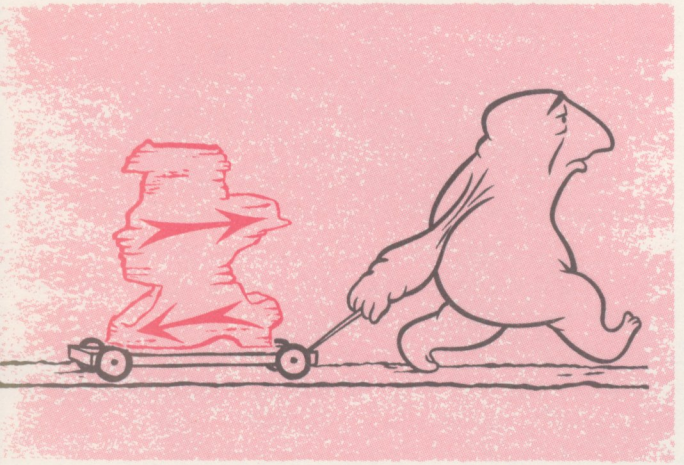
relaxation is restricted.

In the third main group are the sociopathic personality disturbances. The maladjustment is related to nonconformity with prevailing cultural standards. Frequently, sociopathic reactions are indicative of severe basic character disorder; however, the possibility of neurosis or psychosis must be investigated before a definite diagnosis can be established.

Antisocial reaction—incapable of loyalty to any person, group, or code; pursue hedonistic aims without sense of responsibility or judgment; remarkable ability to rationalize behavior so that it seems reasonable, even justified. This category was previously termed "psychopathic personality."

Dyssocial reaction—adherence to values and code of socially unacceptable group, for example, a criminal group; may have strong loyalties, and behavior is consistent with standards established by abnormal environment.

Sexual deviation—may be symptomatic of neurosis or psychosis; without other symptoms of these disorders, perversion is classified as character disorder. Types include



In neurosis, only one aspect of ego-function is distorted, and the patient experiences anxiety.

homosexuality, transvestism, pedophilia, fetishism, and others.

Alcoholism—considered to be a character disorder unless some other specific underlying cause can be established.

Drug addiction — almost always symptomatic of character disorder.

If one particular type of character disorder were to be designated as most common, it would probably be the compulsive personality. The following case history, cited by Laughlin, illustrates some of the more salient features. A 36-year-old man had been treated intermittently for one year because of chronic constipation. During that time, his physician noted certain personality traits which he thought might have some relationship to the physical disorder. Therefore, referral for psychiatric consultation was recommended.

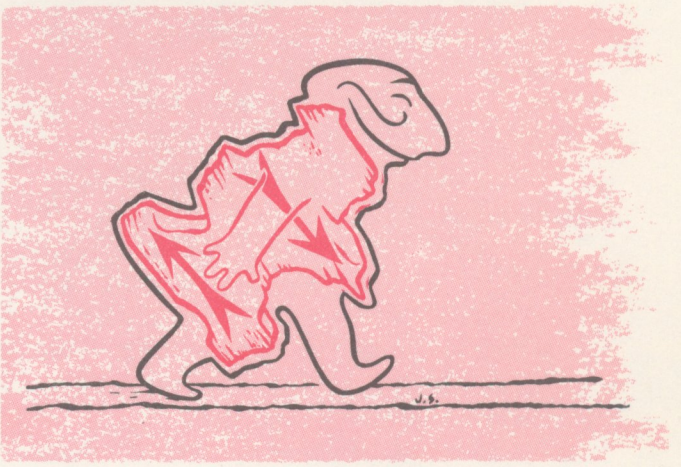
In appearance, the patient was neatly dressed; in manner, he was quiet, precise, and courteous. He was employed as production manager of a manufacturing company, and during the first interview, described difficulty in relationships with the company president. Ostensibly, the conflict seemed to result from the president's wish to increase production, and the patient's insistence that perfection in detail and precision in workmanship should be paramount.

As the analysis progressed, it became apparent that the patient was rigid in his thinking, resistant to change or new ideas, and obstinate with respect to suggestions from others. His personal habits included two thorough shower baths daily, with three or more complete changes of clothing. He was uncomfortable after any interruption of this routine. His relationship to his family was distant, and he seldom mentioned them. In addition to other characteristics, the patient was handicapped by parsimoniousness. This affected the family especially, but was also extended to the business. The process of character analysis was facilitated by the patient's conscientiousness, intelligence, and serious endeavor; but it was prolonged because of his overcaution and obstinacy, and because of his need to control by withholding.

Before the patient was promoted to production manager, his work had been to plan precise, detailed outlines for new products. The promotion had resulted from his success with this meticulous work. In the new position, however, it was necessary that he accelerate the production and increase the quantity.

Treatment continued for more than three years. At the end of that time, the patient had been able to readjust some of his defensive methods, had adapted to his work, and had achieved a closer family relationship.

The treatment of a patient with character disorder necessitates study of the historical development of his individual attitudes, and helping him to a release from the rigidity of his pathogenic defenses. This process is called character analysis. In a sense, all forms of psychiatric analysis are character analyses. However, character analysis is the most thorough type because all facets of the individual's instinct experiences, environmental influences, and interpersonal relationships are explored. In order to effect a change, the patient must first be helped to recognize that his behavior is deviant, and that it is detrimental to him, as well as to others. With this recognition, the patient experiences anxiety. Further



In character disorder, the ego loses its flexibility, and is misshapen. No anxiety is felt.

treatment is then conducted in the same way that patients with neuroses are treated. Fenichel says that the purpose of character analysis is to ". . . change the patient into what he would have become had his life circumstances been more favorable."

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Prognosis in Schizophrenia

● DURING THE 15-YEAR period between 1896 and 1911, Kraepelin, Freud, Meyer, and Bleuler published works which related specifically to the course and outcome of schizophrenia. Some of their suggestions are no longer tenable. Others have been confirmed or are still being investigated. Although the etiology of schizophrenia remains unknown, several methods of treatment have been devised in the past 30 years and have altered outcome in individual cases.

Contributory theories

In 1896, Kraepelin first differentiated as an entity the disorder which he called *dementia praecox*. This designation had been used before by Morel to distinguish the dementia which occurred early in life from senile dementia. As Kraepelin employed the term, however, it meant dementia soon after the onset of disease. Implicit in this use was the idea of inevitable deterioration to a state of idiocy. Kraepelin's classic description of symptoms was admirable for its extension and completeness, but discouraged therapeutic attempts by reaffirmation of the then popular concept of poor prognosis for patients with mental illness.

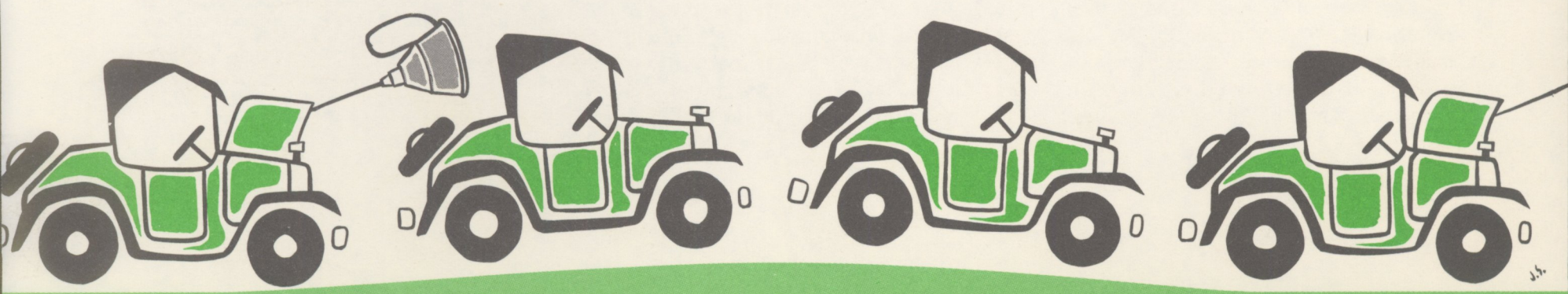
In the same year, Freud published a dynamic interpretation of the symptoms of a patient with dementia praecox, paranoid type. In this paper, the mental mechanism of projection was first described. Two years before, Freud had indicated the process of development of hallucinatory psychosis. Obviously, his entire psychoanalytic theory can be related, directly or indirectly, to the schizophrenic process. Perhaps the most directly related theories were those of the unconscious, symbolization, repression, transference, and regression, although these ideas were not originally formulated in connection with schizophrenia. Freud also believed that the libido of the schizophrenic was withdrawn from external objects, so that transference was not possible.

Meyer, in 1906, advocated the "longitudinal" study of schizophrenic patients. He thought schizophrenia resulted from life-long accumulation of faulty habits of adaptation, called substitutive reactions, and considered these reactions to progress from mild subterfuges to serious symptoms. This concept prompted a search for latent schizophrenia in neurotic patients, and undoubtedly resulted in many early diagnoses of schizophrenia. Later studies of pseudoneurotic schizophrenia were derived from this idea, but, despite reaffirmation of the psychogenic factors, Meyer stated that a psychotherapeutic approach was not usually successful.

Bleuler's monograph on schizophrenia was published in 1911. He enlarged Kraepelin's category of dementia praecox and renamed it the *group of schizophrenias*. The term was chosen to emphasize a split in psychic function, in contrast to Kraepelin's concept of progression. Bleuler accepted Freud's theories of the psychological content of symptoms, and first described ambivalence and autistic thought. Bleuler believed that affectivity was not absent in schizophrenic patients, that apparent apathy resulted from repression, and that emotional response could be stimulated by favorable environmental influences. With respect to prognosis, Bleuler stated that complete recovery was not possible in the sense of return to pre-illness mental status. There was always some residual evidence of disease. Conversely, however, he emphasized that recovery to the degree of a return to useful occupation could be accomplished. This criterion is comparable to the present one of social recovery. About the course of schizophrenia, Bleuler said, ". . . merely the general direction of this disease is toward a schizophrenic deterioration . . . in each individual case the disease may take a course which is both qualitatively and temporally rather irregular. Constant advances, halts, recrudescences, or remissions are possible at any time." With his insistence on the likelihood of schizophrenic emotional response, and the criterion of social adaptation instead of cure, Bleuler initiated a more optimistic attitude toward treatment of schizophrenics.

Methods of treatment

In 1916, Sullivan began his work with schizophrenic patients. His first paper on this subject was published in 1924, and he continued to write until his death in 1949. Sullivan's greatest contribution was in his emphasis upon the importance of interpersonal relationships. Freud's theories had, of course, included relationships to others, but discussion of the interaction between ego and instincts was predominant. Sullivan stated that nothing is intrapsychic or intrapersonal. All thoughts, reactions, and activities are prompted by the individual's relationships with other persons. Sullivan believed that schizophrenia evolved from unsatisfactory relationships, and remarked that it was seldom possible to obtain a good history of a schizophrenic patient from the patient's mother. He was vehement in approval of psychotherapeutic treatment of schizophrenic patients, and reported that 80 per cent of his patients were discharged after psychotherapy. This statement was received with some doubt. The suggestion was made that the patients could not have been schizophrenic. Nevertheless, other therapists have



reported success with psychotherapeutic treatment of schizophrenics.

Other treatment methods have had varied results. First, in 1927, Sakel began the clinical administration of insulin shock therapy to psychotic patients, and, in 1933, reported its effectiveness in treatment of schizophrenics. By this method, a state of hypoglycemia is produced, in which the patient becomes comatose. The level of coma and its duration and frequency are determined individually. Usually, convulsions are avoided, or are induced in limited number for patients with particular types of schizophrenic reaction. The recovery or improvement in schizophrenics after insulin shock therapy has been estimated at between 40 and 60 per cent of all cases.

The form of treatment in which the immediate objective is induction of seizure was first employed clinically by Meduna in 1934. After experimentation with use of camphor and other pharmacological agents, Meduna administered Metrazol® to 101 schizophrenic patients, with resultant total remission in 41 patients. This method, however, had the pronounced disadvantage of a delay between administration of the drug and the reaction. During the interval the patients retained consciousness, and suffered intense fear and anxiety. In 1938, Cerletti and Bini introduced electric shock therapy. This method was technically simpler, induced almost immediate unconsciousness, and it promptly replaced the pharmacologic method. The number of electric shock treatments in a single course usually varies from eight to 20 treatments. In a study of 455 schizophrenics of different types, 43.8 per cent were improved after one course of electric shock therapy. The improvement after electric shock therapy may not be a lasting one, however. The rate of relapse is high unless adjunctive therapy is provided. Sometimes both insulin and electric shock therapy are administered. An example of the results of this combination is a report of recovery in 64 per cent of 682 cases. In general, shock therapy is most effective for patients with acute onset of symptoms. It is least effective for schizophrenic patients under 18 years of age.

Psychosurgery, an ancient practice, was reintroduced by Egas Moniz in 1935. Schizophrenic patients who have not responded to less drastic methods of treatment have been treated by prefrontal lobotomy, or a variation of this procedure. Advocates of psychosurgery have reported favorable results. Postoperatively, some patients are able to be discharged, and those who remain in the hospital are more manageable. The personality alteration which results from psychosurgery is irreversible, though, and, unfortunately, often has undesirable features. Since it is known that even in cases of advanced, chronic schizophrenia improvement is possible, a decision for operative intervention is made with great caution. Furthermore, a permanent alteration precludes application of newly discovered therapies.

Tranquilizing drug therapy is an example of new methods of treatment. At present, the tranquilizer most frequently given is chlorpromazine. This drug was introduced in the United States in 1954. Delay and Deniker had first reported its administration to psychotic patients in France in 1952. Chlorpromazine has proved effective in treatment of patients with either acute or chronic schizophrenia. In acute cases, anxiety, psychomotor activity, and aggressiveness are reduced. In chronic, regressed cases, improvement to the degree of basic self-care has resulted. According to Arieti, administration of chlorpromazine enables the ambulatory schizophrenic to respond more favorably to psychotherapy. The adverse effects of chlorpromazine include Parkinsonism, hypotension, dermatitis, jaundice, agranulocytosis, and depression. The side-effects may be controlled by use of counteractive agents, reduction of dosage, or withdrawal of the drug.

Of the different treatment methods, induction of insulin coma or the administration of a tranquilizing drug, and concurrent psychotherapy with either type of physical treatment, have had the most favorable results. Subsequent investigations may demonstrate the superiority of one of these methods of treatment.

Individual prognosis

Until the etiology of schizophrenic reactions has been determined, and the mechanism of the disease process is fully understood, it will not be possible to delineate individual prognosis. Attempts have been made to predict outcome on the basis of such factors as heredity, constitution, temperament, rate of onset, type of disorder, severity of symptoms, and others. However, there has not been sufficient consistency of findings to form a reliable basis for prediction.

It has been noted, however, that certain symptoms occur frequently in patients who recover, and other symptoms are evident in patients who do not. Arieti has listed these as favorable and unfavorable signs. Conscious anxiety is favorable when the patient reacts by an effort toward realistic thinking. Anxiety is unfavorable, however, when it evokes greater withdrawal. An attitude of compliance indicates a likelihood of recovery. When the patient is defiant, he attempts to reinforce his attitude with psychotic mechanisms. Depression is a favorable sign; the prognosis improves proportionately to the quality of affective behavior. Hopelessness without depression, however, is an ominous indication. The content of delusions and hallucinations is significant. Usually, projection of guilt to others, with self-exoneration, is a poor prognostic symptom. If delusions are related to feelings of personal guilt or responsibility, the prognosis is better. An exception to this is the situation in which there is a delusion of excessive power. The type of insight is a significant factor. There are two types which occur in schizophrenia. The first is called

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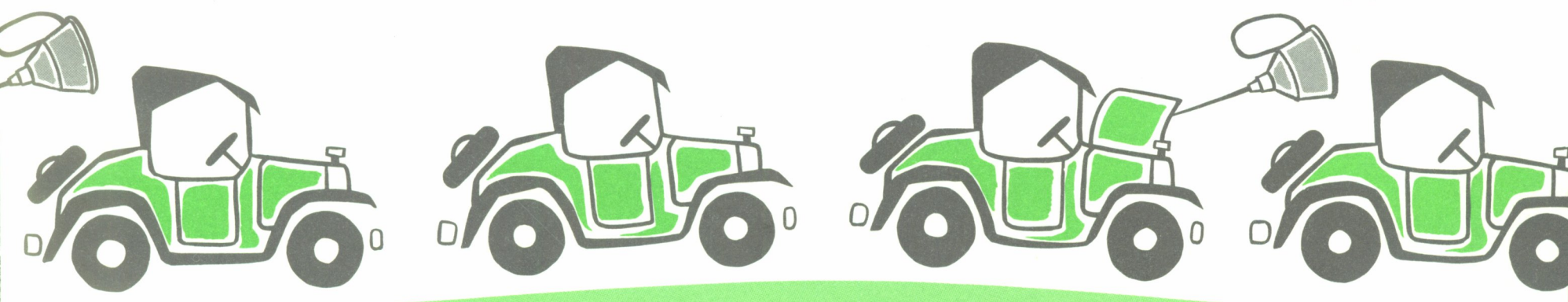

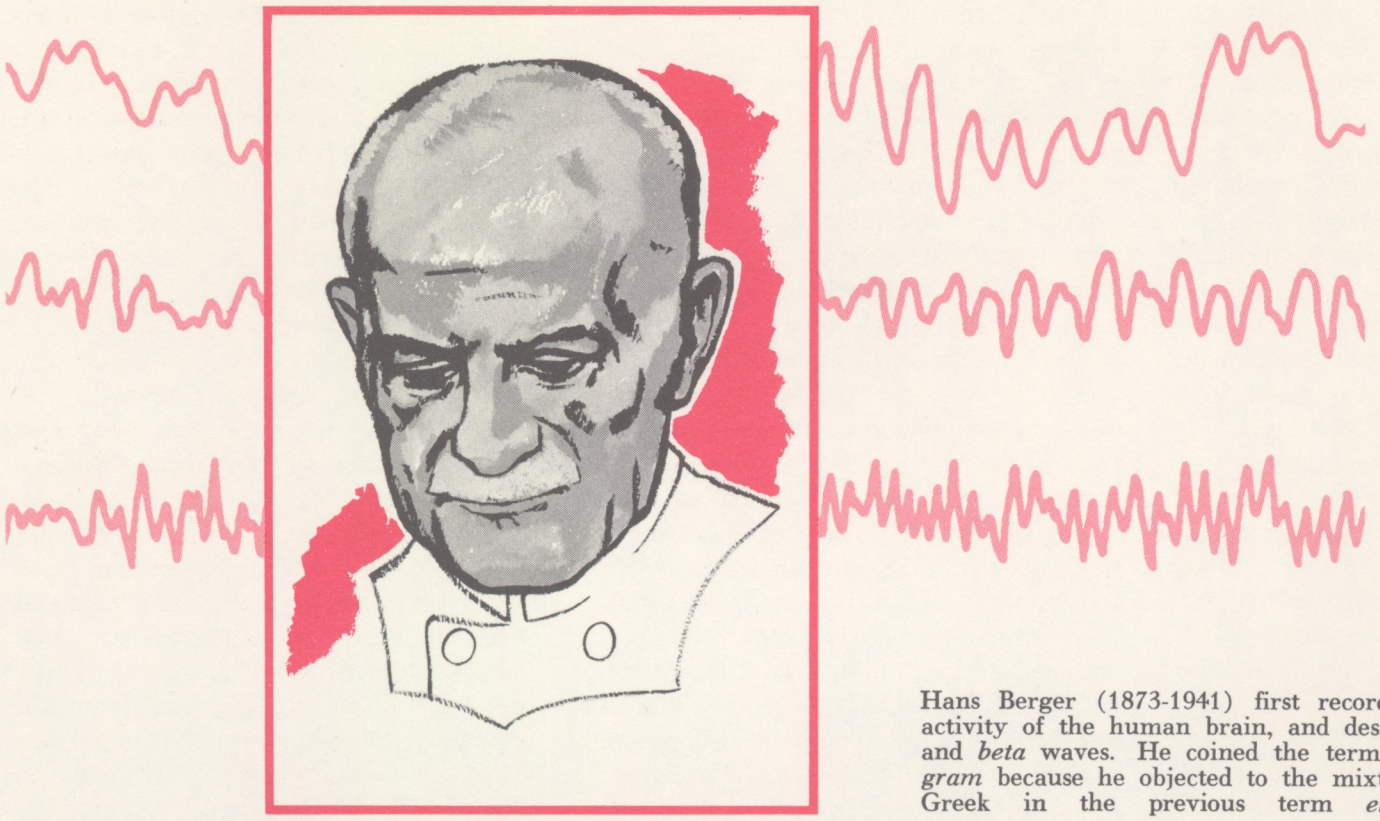

Hans Berger (1873-1941) first recorded the electrical activity of the human brain, and designated the *alpha* and *beta* waves. He coined the term *electroencephalogram* because he objected to the mixture of Latin and Greek in the previous term *electrocerebrogram.*

Electroencephalography in Psychiatry

● In the opinion of many observers there is a correlation between psychogenic disorder and abnormal electroencephalographic tracing. A higher incidence of deviant patterns exists among individuals with some types of functional illness than in the general population. Some reported studies have been criticized because of variability in patient sampling and in criteria of abnormality. Others have been considered inconclusive because there was no similarity of electroencephalographic disorder in patients with the same mental illness, and, frequently, patients with severe derangement have normal patterns. Despite differences of opinion, however, the findings in several controlled studies apparently have significant practical value.

Criteria

Evaluation of electroencephalographic tracing differs, to some extent, according to the particular investigator's interpretation. The generally accepted normal findings are alpha rhythms (eight to 13 cycles per second) and beta (low-voltage fast activity) during wakefulness, and delta waves (slower than four cycles per second) with spindle bursts of ten to 14 cycles per second during sleep. Paroxysmal activity, focal disturbance, and definite asymmetry are abnormal at any time. The margins which necessitate interpretation occur as moderately slow activity (five to eight cycles per second) and symmetrical higher-voltage fast activity. It is within these margins that most of the deviant patterns of psychiatric patients are found.

Gibbs and Gibbs outlined a system of gradation to classify degrees of deviation. The designations of S1, S2, and S3 are applied to slightly slow, moderately slow, and exceedingly slow activity; F1, F2, and F3 indicate, correspondingly, the faster than normal activity. Gibbs and Gibbs noted that S1 and F1 tracings are significant only in relation to other evidence of disorder. These criteria, or modifications of them, have been accepted by many investigators. The results of electroencephalographic studies of patients who have emotional disturbances can be illustrated by representative reports in some of the different classifications of mental illness.

Psychoses

The incidence of abnormal patterns in schizophrenia has been cited as from five to 60 per cent. Colony and Willis reported five per cent abnormality (slow wave activity) in a study of 1,000 schizophrenic servicemen whose average age was 20.4 years. The control group of 474 patients of comparable age, without discernible psychosis, had 8.3 per cent similarly abnormal tracings. The authors concluded that electroencephalographic abnormality in schizophrenia is less common than in nonpsychotic emotionally ill patients of approximately the same age.

Kennard and Levy found that 60 per cent of 100 schizophrenic patients (aged 16 to 60) had abnormal tracings. The deviation was described as high-voltage fast activity, particularly in the frontal areas. The patterns were unusually irregular and dysrhythmic, with a rate of 17 to 20 cycles per second. Other factors related to the incidence of abnormality

included early onset and long duration of illness, and family history of psychopathologic disturbance.

In a review of ten different studies, Ellingson reported that nine of them were concluded with the observation that electroencephalographic abnormality is greater among schizophrenics than among normals. He estimated the rate as one-fifth to one-third higher. In the schizophrenic subgroups, patients with catatonic reactions had the highest rate of electroencephalographic abnormality, and those patients with paranoid reactions had the lowest rate.

Manic-depressive patients have shown tracings of strong alpha rhythms, or mixed slow patterns in depressed patients. Patients in manic state recorded rapid alpha patterns of ten or more cycles per second; however, evidence in manic-depressives is insufficient for conclusion.

Earlier reports of involutional psychotic patients showed abnormally fast tracings in both depressive and paranoid types. Later study, however, has established that fast patterns are not abnormal in older persons. Gibbs and Gibbs qualified the F1 rate as normal after the age of 40.

In general, the electroencephalographic pattern of a psychotic patient remains constant during illness. A change in the tracing usually corresponds to a clinical change.

Neuroses

The reported incidence of electroencephalographic abnormality in neurotic patients has varied considerably. In eight different studies, four groups of patients with undifferentiated neuroses were reported as having from 23 to 34 per cent abnormal patterns. Three similar groups showed abnormality of two to 14 per cent, and, in one study in which 100 neurotics were compared with 500 controls, the neurotics' rate of abnormal pattern was cited simply as low. Gibbs reported the incidence of abnormality in control groups as 15 per cent. If this is considered representative of the normal population, then the results of the eight studies are equally divided into normal and abnormal electroencephalographic findings in neurotic patients. Seemingly, evidence of abnormal patterns in neurotic patients is neither consistent nor conclusive. It may be that the irregular patterns of some neurotic patients result from the patients' inability to relax during the test.

Psychopathic personality

Of all types of emotional illness, the one with highest incidence of electroencephalographic abnormality is that of antisocial reaction. Patients with this disorder have shown deviant tracings consistently. Even in separate studies, the percentage of abnormal patterns in this group has been cited with unusual regularity as from 47 to 58 per cent. The type of deviant pattern most commonly reported is S2 activity. S3 and paroxysmal tracings have also been observed more frequently in psychopaths. Although no relationship has been established between degree of electroencephalographic abnormality and severity of psychopathic disorder, several other factors have been correlated. First, the deviant pattern is inversely related to age; family history of mental disorder and personal history of injury are significant; and aggressiveness is a common feature in psychopaths with abnormal tracings.

Erlich and Keogh reported a detailed study of 50 psychopaths (38 men and twelve women) in a mental institution. The patients were all under 50 years of age. The authors noted that such individuals seemingly cease to be problematic after the age of 45, or at least their deviations become less obvious. Of the entire group, 80 per cent had abnormal electroencephalographic patterns. The abnormalities were alpha variant (slow), excess theta (four to seven cycles per second), dominant theta, and temporal slow wave focus. Other factors in the group with cerebral dysrhythmia included history of early physical trauma, and less synthetized, relatively weak ego. These patients came to the hospital of their own volition early in the course of disorder, and were more receptive to treatment. The authors stated that further investigation may establish definite organic cause of illness in psychopaths with abnormal electroencephalographic patterns. The patients with normal tracings had low incidence of physical injury but a higher ratio of such psychologic trauma as early emotional deprivation and faulty identification models. The personality patterns were deviant but stabilized, and resentment against any realistic challenge of the illusion of omnipotence was evident. These patients came unwillingly to the hospital late in the course of disorder and were resistive to treatment. In both groups, there was a high incidence of self-destructive tendency, evidenced in suicidal attempts or accident proneness. The authors considered this a noteworthy finding in individuals who are generally considered to be "without conscience."

The electroencephalogram has been used in clinical practice for more than 20 years. Although it has been of undeniable value in elucidation of some types of disorder, this test should be used only as an ancillary method of diagnosis. Occasionally, too much dependence has superseded good clinical judgment. For example, Bergman and Green cited the case history of a boxer who suffered from double vision and ataxia. He had been a capable athlete, but, since the onset of symptoms, had been knocked down repeatedly. Despite evidence that a brain lesion had caused his loss of skill, he was permitted to continue to box because his electroencephalographic tracing was normal.

In the investigation of electroencephalographic data of psychiatric patients, there are many interpretive aspects which are still unknown. Application of findings must, therefore, be considered significant only in relation to clinical evidence.

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Mental Disorders a

● ENDOCRINE AND MENTAL DYSFUNCTIONS have an intricate relationship. Acceleration or diminution of thyroid activity can cause mental disorder, result from mental disorder, or, as Gregory has pointed out, the two dysfunctions may coexist. The complex activities of the adaptive hormones are by no means fully understood, and further study is needed of the reciprocal nature of mental and thyroid malfunctions to determine the degree of retroaction. Hypothyroidism is usually considered somatopsychic in origin, although instances have been reported of development after emotional crises. Hyperthyroidism, however, is believed to be psychogenic in etiology. Normal intellectual function necessitates normal thyroid secretion, and disordered function of the gland causes psychologic changes as conspicuous as the known bodily changes.

Studies of endocrine secretions in mentally diseased patients have corroborated abnormality in many instances. Several investigators have compiled indices of thyroid activity and of response to thyroid stimulating hormone among hospitalized patients. Computations have also been made of thyroid function in psychiatric patients before and after electroconvulsive or insulin coma therapy. Although many of the reported findings are still statistically small and insufficient for therapeutic conclusions, they yet further demonstrate the interrelationship between mentation and endocrine status.

Hyperthyroidism

The patient with thyrotoxicosis is restless, excessively sensitive, often sanguine, temperamental, and alert. He defends against insecurity by sustained efforts at being self-sufficient. His disorder is precipitated by emotional tension, and the symptoms have much emotionality about them also. Besides such signs and symptoms as enlarged thyroid, tachycardia, exophthalmos, diarrhea, and raised basal metabolic rate, there is also an obvious increase in anxiety. Such patients manifest irritability, insomnia, profuse sweating, capriciousness, and instability of mood. The circumstances of stress that initiate acute hyperthyroidism are grouped, by Lidz, into three kinds. First are serious emotional crises that traumatize seemingly well-adjusted individuals, as in instances of sudden and unexpected bereavement. Thyroid disease from this sort of precipitant is, apparently, uncommon. In the second category the severity of the stimulus is less obvious; that is, the incident that precipitates illness is disturbing in a way particular to the patient, because the disruption or alteration affects vitally the patient's particular form of defense. The third group of circumstances includes occurrences or events that abolish whatever environmental system of safety the patient has evolved. The particular events may be hard to determine, but they precipitate hyperthyroidism in individuals who were previously unstable. When security is destroyed by social change, for instance, and hyperthyroid attacks occur, the patients are, commonly, obsessive personalities, in whom anxiety has had more visible effect. Such persons are often phobic, compulsive, and unable to be factual about their situations.

The history of the patient with Graves' or Basedow's disease usually includes a fear from extremely early years of being deserted or rejected by a parental figure. Sibling rivalry, hostility, and overcompensation from the dread of isolation are a familiar pattern. Compulsive unselfishness is characteristic, as it is, for many patients, the way to represent that parent figure by controlling and becoming necessary to someone else. A determination to become pregnant is, logically, a consistent feature, and dreams of death are often reported. The syndrome is one of terror, and the expression "frozen fear" is all too descriptive of thyrotoxic patients.

Because of pre-existing personality disorder, therapy is not a simple matter. Obviously, although spontaneous remissions do occur, it is dangerous to risk further metabolic crises, and exacerbations of disease are also frequent. The physician's initial effort will be directed toward correction of thyroid imbalance, but psychotherapy is indicated, too. Psychiatric referral may be necessary, because even thyroidectomized patients will have still, after the "crystallized fright," the problems temperamentally inherent. They will still be individuals with assorted maladaptations, who have constructed elaborate and unsuccessful defenses against insecurity, and who have always required more love than they could receive. Antithyroid treatment is not always successful or adequate or is only temporarily so, and psychotherapy, without medication, is also thought to be dangerous. D. Stanley-Jones has described the thyroid as the "thermostat of the body" and says, "Thyroid anxiety results from an endogenous blockage of the oral outlets for fear or hate, the post-hypothalamic discharge being diverted to the pituitary."

Hypothyroidism

The patient with Graves' disease has a functional disorder that becomes organic. The patient with

nd Thyroid Disease

athyreosis, or hypothyroidism, has, as expected, a type of personality antithetical to that of the hyperthyroid person. As hypothyroid patients do not conform always to the expected or predicted, missed diagnoses of myxedema can and do occur. The dull and apathetic patient who has lost weight, whose memory is impaired, and who suffers from leg pains and generalized weariness may suggest to the examining physician an instance of depression or of a presenile state. Symptoms and signs such as gradual deafness, lethargy, hair loss, hyperpnea, increased sensitivity to cold, and dryness of skin may not be mentioned by the patient, and will be elicited only by the physician's questions. Seeming or actual intellectual retardation further confuses the clinical evidence. Some years ago Reitan reported Rorschach test findings in a group of myxedematous subjects. Mental activity was impaired to a degree between that of brain-damaged patients and that of neurotic ones, although the specific type of dysfunction was incompletely indicated.

With the development of improved thyroid medications sudden and definitive improvement became possible for hypothyroid patients unless the deficiency had been missed and allowed to persist for too long a time. Amelioration of the condition before psychotic development depends, however, on recognition. In such patients the basal metabolic rate is of little diagnostic help, and, in the opinion of Asher, many of the expected manifestations, such as bradycardia, are rarely discernible or fail to occur. In his opinion, comparison of photographs, made one to two months apart, is the best of confirmatory tests, with elevated blood cholesterol as the second best. He believes that myxedema is a much more important and frequent cause of organic psychosis than many realize, partly because of the inconstant nature of the resultant psychoses. In the psychotic myxedematous patient general disorientation and delusions of persecution are common, but type of psychosis is not diagnostic. Asher says, "No physician would attempt to diagnose lobar pneumonia or typhoid by the delirium they may produce, and likewise in myxoedema it is the disease which is the characteristic feature, not its mental manifestations."

This physician reported 14 psychotic patients, none of whom had been diagnosed by the referring physician, and nine of whom recovered after thyroid medication. In two patients there was only partial recovery, in one no change, and the other two died in less than a week after admission. Asher remarked that, "If one observer can encounter this number in four years it must mean that there are many others . . . If the diagnosis is borne in mind by psychiatrists a number of otherwise hopeless psychoses may be cured, and the awareness of an organic cause for one psychosis may lead to the discovery of physical causes for others which are at present dismissed as of psychological or idiopathic origin."

Alexander has commented upon sub-clinical myxedema that coexists with chronic neuroses in patients with depression, fatigue, and anxiety. He cited an instance of a 28-year-old female patient in a state of anxious depression. She had had psychoanalytic therapy without improvement and, at the time of the report, had been for three years receiving psychotherapy with only slight results. When it was belatedly discovered that the patient was hypothyroid with additional hypoferric anemia, thyroid and iron were prescribed and administered. The rate of basal metabolism rose in a month's time, and she was mentally greatly improved for about two months. She then relapsed into her former neurotic state. Psychotherapy with subconvulsive electrical stimulations and thyroid administration was continued, and after a year the patient was demonstrably improved. Six months later she was clinically fully recovered and has not since had any recurrence of symptoms.

Obviously neither medical nor psychiatric treatment can be neglected in instances of thyroid malfunction. The examining physician who attempts fully to comprehend the personality problems of the patient can better decide the proper course in the alleviation of mental alterations that are produced by or are concomitant with thyroid disorder.

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MONGOLISM

● THE EXACT ETIOLOGY of mongolism is unknown. Theories of cause may be divided into two groups. The first group consists of theories of germ-cell causation, which include heredity, gametic mutation, or fertilization of defective ova. In the second group are theories of environmental deficiencies which include poor implantation of the fertilized ovum, maternal endocrine imbalance, particularly hypopituitarism, or disorders in the embryo such as anoxia or infection. Some of these theories are not generally accepted. For example, mongolism is probably not heritable. The occurrence of more than one mongoloid child in a family is rare. A high percentage of mongoloids die shortly after birth and those who survive are not able to compensate for their deficiency and cannot achieve physical or mental maturity.

Mothers of mongoloids

The majority of mongoloids are born to women over the age of 35 years. At the age of 45, the likelihood of mongoloid offspring has been estimated as high as one in 25 births. It is not known whether this incidence is the result of physiologic alteration in germ plasm, or loss of some protective factor peculiar to younger women. Although the age of the mother is undoubtedly a contributory factor, it obviously is not specifically causative, since most older women produce normal children.

Histories of long periods (three to 18 years) of involuntary sterility are commonly reported. In women who have been pregnant, the incidence of habitual abortion, miscarriage, and premature delivery is high. A predominance of thyroid disorder has been noted in the younger mothers, as well as pregravid menstrual irregularity and bleeding during gestation of the mongoloid child.

In a study of 107 mothers of mongoloids, 62 were described as nervous, tense, easily upset, and "high-strung." This emotional lability is characterized by instability of circulatory and autonomic functions. It is of interest that during World War II the number of mongoloid children born to women in concentration camps was more than three times greater than the expected frequency.

Benda has advised endocrine studies during early prenatal care for women whose histories show a likelihood of mongoloid birth. The information obtained from such studies would be helpful in designation of specific measures to prevent abortion and ensure optimal maternal health. In addition, statistical evaluation of sufficient data might elucidate means for prevention of the development of mongoloid characteristics.

Diagnosis

Diagnosis of mongolism can be made at birth. An x-ray of the skull

will show underdevelopment of the visceral skull and basilar bones, and small, egg-shaped orbits. The anterior fontanel is unusually large and all sutures may be separated. Normally, the frontal suture is not present at birth; in the mongoloid, however, it may be palpated to the nasion. Distinctive clinical features include the fetal epicanthal fold, short face in contrast to large forehead, sunken bridge of nose, spade-like hand with low-set thumb and short fifth finger, and a gap between the first and second toe. Frequently, there are also multiple congenital anomalies not related specifically to diagnosis of mongolism. The mongoloid abnormalities become more conspicuous within a few weeks after birth, not because pathologic features are increased, but because of lack of normal development. It is advisable, therefore, to delay final judgment for several weeks until diagnosis of mongolism can be made without question.

Therapy

Although there is no specific therapy for mongoloid children, there are several measures which have been reported as helpful. The administration of desiccated thyroid, in doses of one-tenth of a grain three times daily for infants and one to three grains daily for older children, results in improved general physical condition and counteracts listlessness. In a report of 50 cases in which pituitary growth hormone was given with the thyroid extract for six years, 30 per cent of the patients attained a mental age between five and eight years. Without any treatment, mongoloids seldom progress to a mental age of more than five years.

Kaplan reported the use of x-ray therapy for a 14-year-old mongoloid girl who was unable to talk, understand conversation, or feed and dress herself. Irradiation of 75r was administered to the pituitary gland three times a week for six weeks. A month after therapy, the patient was able partially to dress and feed herself, seemed to understand what was said to her, and replied in simple sentences. A second course of irradiation was given a year later, and a third after four months. The patient maintained the advances which occurred after the first series of x-ray treatments, but there was no evidence of continued improvement.

Care and education

Optimal development of a mongoloid child can be achieved only in an environment in which his emotional needs are met and his peculiarities in learning are understood. If the parents accept the fact that the child will always be limited, and if they can provide the love and attention he requires, there is no question that the child will profit from being at home. In such an atmosphere, the

mongoloid is usually an affectionate, quiet, and even-tempered child. In contrast, the restless, stubborn, destructive behavior which characterizes some mongoloid children results from parental attitudes of rejection, shame, and constant correction of the child. The siblings usually adopt the parental attitudes, whether they are favorable or unfavorable.

The factors over which parents have little control include the neighborhood attitude, the comments of other children, and the problems inherent when younger, normal siblings surpass the elder ones in mental and physical accomplishment. A particularly adverse situation is that in which the interests of the entire family are secondary to the care of the mongoloid child. Such sacrifice is most inadvisable, since both the family and the defective child will, eventually, react in some manner to the underlying hostility.

The degree of maturation of mongoloid children varies individually. As a general rule, the rate of progress is about 50 per cent less than that of a normal child of the same age. A well-cared-for mongoloid child may be expected to learn to walk at about two years of age, and to talk between the ages of two and a half and three and a half. He may be able to go to kindergarten at the age of six or seven, and enter the first grade at nine or ten. Scholastic capabilities include good memory, and a large vocabulary and excellent spelling ability are not unusual. Arithmetic is difficult for the mongoloid. The concept of quantity is not easily recognized, and, therefore, management of money is seldom possible. Abstract thinking will never be fully developed; therefore, education should be directed toward the teaching of practical skills. An older mongoloid child will enjoy household duties, and may be able to perform them fairly well.

If a mongoloid child who has lived at home is to be institutionalized, it should be done when he is 13 or 14 years old. The adjustment is more difficult after the age of 20. With a satisfactory milieu from birth to early teens, the mongoloid has been given a good beginning. After that period, psychologic and emotional isolation becomes more pronounced, and the mongoloid may be happier with the compatible friends, occupational facilities, and entertainment programs provided in institutions.

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PROGNOSIS IN SCHIZOPHRENIA

Continued from page 73

psychotic insight, and is not a favorable sign. After a period of mental confusion, the patient suddenly believes that he is exceptionally lucid, and may even convey this impression to others. The frame of reference, however, is distorted. Insight in which the patient understands that he has been ill (a process similar to recognition of the unreality of a dream) is a much better prognostic indication. Finally, the ability to lie is an excellent symptom; in fact, it is evidence of the process of recovery. Delusions are not the result of pretense or deliberate imaginings; they represent reality to the patient. Therefore, as long as the patient is ill, he cannot deny them, or even pretend that they do not exist. When the patient can lie about his delusions, for any purpose, he has at least recognized the existence of another viewpoint. In time, there will be no necessity for untruth because the delusions will disappear.

General prognosis

A comparison between general prognosis in schizophrenia 50 years ago, and present-day expectancy is of interest. In 1905, Bleuler reported the outcome for 515 hospitalized patients. After the first schizophrenic episode, 307, or 60 per cent, were discharged; 92, or 18 per cent, had moderate deterioration; and 116, or 22 per cent, had severe deterioration. According to Freyhan, Bleuler's 22 per cent with severe deterioration corresponds to the present-day figures in similar studies, and it is doubtful that any higher percentages of improvement are attained now. It would seem, then, that the general prognosis in schizophrenia today is comparable to what it was in 1900.

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STATUS EPILEPTICUS: Continued or rapidly repeated convulsive seizures constitute a medical emergency. Death may result from exhaustion, cardiac failure, or brain damage. In order to stop the seizure promptly, anticonvulsants should be given intravenously. The agents used include barbiturates or two to three cc. doses of paraldehyde with 50 cc. of 50 per cent solution of glucose. If neither of these is effective, an anesthetic should be administered, with a surgical level of anesthesia maintained for a minimum of one hour. In all cases in which a respiratory depressant is used, apparatus for artificial respiration should be immediately available.

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EMOTIONAL RESPONSE TO HYPODERMIC INJECTION: Reactions were observed of 133 children during 328 individual injections. The greatest variation in response was noted at different age levels, with a degree of consistency in reaction among children of the same age. Patients were observed before, during, and after administration. According to the tabulated findings, in the first six months of life anticipatory fear was absent, and the injection produced moderate resentment during and after administration. From the age of six months to four years, preinjection anxiety and postinjection resentment were intense. After four years of age, the children showed progressive compliance and control, with the exception of a slight decrease in tolerance between the ages of six and seven. By the age of ten, less than 20 per cent of the group retained the earlier behavioral indications of fear or reluctance. Instead, for the majority, a feeling of pride seemed to supersede, with an apparent wish to maintain self-control. The author cited this effort toward self-control as indicative of emotional maturity, and observed that lack of it might be considered a clue to emotional imbalance in the ten year age group.

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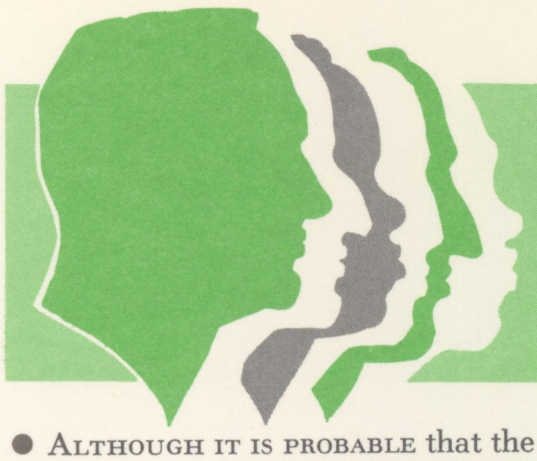
MANAGEMENT OF NEUROTIC PATIENTS: The author has listed five principles which may be helpful in the care of neurotic patients in general practice. One of the most important therapeutic factors is that of *sympathetic listening*. Although listening may seem an inactive kind of treatment, its efficacy has been proved. Because of time limitations, it is suggested that a schedule be arranged in which the patient can depend upon an interview at stated intervals. For example, a weekly session of 20 minutes would be of great benefit in many cases, and the number of sessions could gradually be decreased. The patient should not, however, get the impression that the frequency of interviews depends upon symptoms, because this may result in unconscious maintenance of them. *Clarification and advice* should be limited to assisting the patient to make decisions. Advice to stop worrying is useless, since the patient usually has tried without success to stop. If the solution to a problem seems obvious, and the patient does not recognize it, the reason for this lack of recognition should be determined. *Reassurance* is effective only when it is valid and understood. For example, a pronouncement that there is no organic disorder might be intended as reassuring, but may be interpreted in an opposite way by the patient. *Medication* is a useful adjunct to the interviews as long as the patient knows that it is not the primary agent of improvement. Emotional dependency upon medications may result in an endless search for a curative drug. *Environmental manipulation* should be done with caution. In some cases, as a temporary measure, it may provide partial relief from anxiety, as in postponement of medical bills, for example. In others, however, the patient may unconsciously prolong disturbance in order to avoid responsibility and retain secondary gains. Lastly, although psychiatrists must limit the number of their patients in order to provide adequate therapy, it is possible, in many instances, to arrange for psychiatric consultation. In this way, the psychiatrist may suggest a particular approach which would be of benefit to the patient, and a workable physician-psychiatrist relationship can be established.

Aldrich, C. K.: The Physician and the Neurotic Patient, M. Clin. North America **42**:555 (March) 1958.

INFERTILITY: A routine psychiatric examination is recommended as part of the diagnostic evaluation of infertility. This procedure would be valuable in several ways: first, in detection of patients for whom pregnancy is contraindicated, such as in disturbed patients who would be likely to develop postpartum psychosis; second, in designation of patients whose infertility is psychogenic and who would, therefore, require psychotherapy for correction; and, third, for patients who have no organic disorder but whose superficial conflicts can be alleviated enough to allow conception. Even patients with organic disorder will be benefited by reduction of associated anxiety.

Kummer, J. M.: Value of Routine Psychiatric Examination in Treatment of Infertility, Am. Pract. & Digest Treat. **9**:383 (March) 1958.



CULTURAL INFLUENCES in Mental Illness

● ALTHOUGH IT IS PROBABLE that the range of personality is similar in any cultural group, a considerable variation exists in the emphasis placed upon particular traits. As a consequence, different patterns of cultural organization seem to produce specific types of mental illness. The results of cultural influences which are different from our own have been described in the extensive reports about primitive societies. The comparatively low incidence of mental disorder in some primitive groups has been attributed, in part, to permissive methods of early child care. Of equal importance are the puberty rites in which ceremonies are performed in celebration of adolescence. This custom is believed to help the adolescent to make the transition from childhood to maturity.

Although in our own society most of the members have come from formal cultures which do not differ greatly, there is still distinct variation in the concepts of the different subgroups. This variation is evident in the incidence of types of mental disease in each group.

In a study of 1,963 patients who had received psychiatric care, the subjects were divided into four categories of origin which included Irish, Italian, Jewish, and Negro. The incidence of types of emotional disorder was noted in each category. The Irish showed an exceedingly high rate of alcoholism, a high rate of drug addiction and of senescent disorder, and a low incidence of neurosis. In fact, not one Irish immigrant had been treated for neurosis. The Italians showed a predominance of affective disorder and senescent illness, and a low rate of alcoholism. The highest incidence of neurosis occurred in the Jewish group, which also had the lowest rate of senescent disorder, and no alcoholism. It was noted that affective disorder, which has popularly been considered frequent among Jews, has seemingly decreased in successive generations. The Negroes were found to be extremely low in affective disorders, moderately high in alcoholism, high in senescent illness, and highest of the groups in organic psychosis. Three-fourths of the Negroes with organic disease had paresis, a ratio cited as considerably lower than previous studies have shown.

In a discussion of the cultural factors which may influence formation of these symptom patterns, the following explanations were suggested. The willingness of Jews to accept psychiatric tenets may account for the exceptionally high number who were treated for neurosis. The Jewish religious doctrine is not incompatible with psychoanalytic theories, nor does acceptance of psychiatric care disturb the social values of Jews. In contrast, among Catholics there is some religious opposition to psychoanalytic concepts. Although this explanation of the greater numbers of Jewish persons treated for neurosis is plausible, it may also be that the actual incidence of neurosis is higher among Jews. The high rate of alcoholism among the Irish has been explained as a result of their general acceptance of alcohol as a means for release of tension. It is remarkable, however, that this one form of escape provides an outlet for many different types of emotional conflict. Conversely, inebriety is so strongly disapproved by Jews that this method of tension release is generally precluded for them.

The incidence of senescent illness in the Irish, Italian, and Jewish groups was much higher among the foreign-born members than the native-born of comparable age. Since a loss of recent memory is characteristic of senescent disorder, it may be inferred that adaptation to American culture which is learned later in life is more readily forgotten, with resultant increased difficulty in adjustment to the problems of old age.

The distribution of schizophrenia was not affected by these categories. Other types of grouping, however, have shown varied incidence of schizophrenia. For example, there is, seemingly, a higher incidence in urban populations, particularly in the lower economic groups. Even within the city, a spatial distribution has been demonstrated. The disorder occurs in a definite pattern of highest incidence in the center of the city, next highest in the apartment districts around the center, and lowest in the residential periphery. Incidentally, a similar pattern is shown for senile dementia, but not for manic or depressive psychosis. One explanation for the spatial distribution of schizophrenia is that the stress and rapid pace of city life are more conducive to development of this disorder than is the slower, less competitive rural life. It may also be, however, that mental disorder which is a handicap to the city dweller is tolerated in rural areas as long as the individual is able to work.

Other environmental factors also affect the content of delusion. In a study of 500 white patients and 300 Negro patients, the following differences were observed. Lack of education and low economic status were directly related to paranoid delusions; grandiose ideas were positively correlated with education. Delusions of persecution were more common among foreign-born patients, white women, and northern Negroes. Delusions about money were common among the white patients, and religious delusions were more frequent among the Negroes. The incidence of religious delusion was higher in Protestants than in Catholics; Jews did not have any religious delusions.

The present stage of investigation into the cultural features of mental illness seems to be that of observation and report. Few conclusions have been formulated, and those that have are largely conjectural. Further psychiatric study with the benefit of anthropologic perspective will undoubtedly result in deeper insight.

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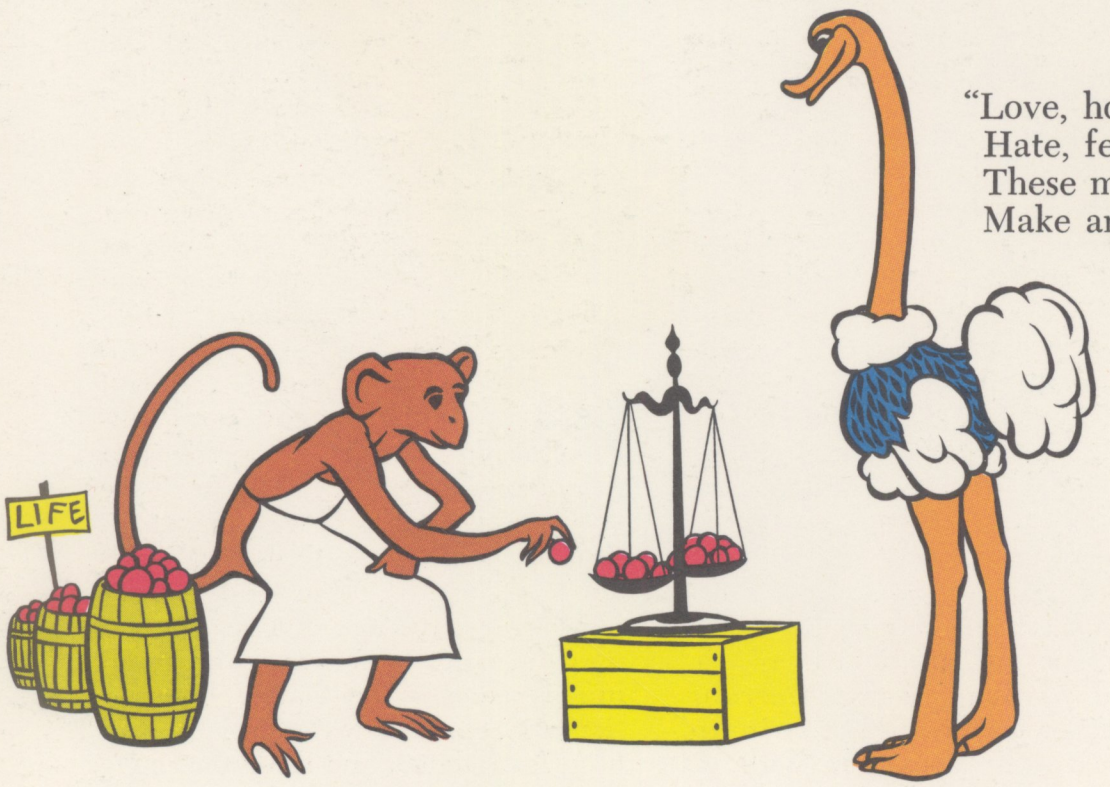

"Love, hope, and joy, fair pleasure's smiling train,
Hate, fear, and grief, the family of pain,
These mix'd with art, and to due bounds confin'd
Make and maintain the balance of the mind."

ALEXANDER POPE, 1732